Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPREHENSIVE PAIN MANAGEMENT
5734 SPOHN DRIVE SUITE A
CORPUS CHRISTI TX 78414

Respondent Name
ZURICH AMERICAN INSURANCE CO

Carrier's Austin Representative Box
Box Number 19

MFDR Tracking Number
M4-10-5170-02

MFDR Date Received
APRIL 30, 2010

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "Carrier denied calim for 'W11-Entitlement to benefits. No finally adjudicated and 851-payment disallowed."

Amount in Dispute: $1,746.40

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "**The EOBs raise underlying issues of causal relation**. In particular, the EOBs indicate that the treatments underlying the charges in dispute were for body parts and/or conditions not related to the compensable injury. To the extent that there has been no final resolution of this liability dispute and in accordance with 28 TAC Sections 133.307(e)(2)(D), 133.308(f)(7) and/or 133.308(t), any request for resolution of a fee dispute and any request for an IRO must be held in abeyance until such liability disputes have been resolved by a final decision of the TWCC. Carrier will not be liable for an IRO fee incurred as a result of any referral in violation of this rule of abeyance. Further, the carrier challenges whether the charges are consistent with applicable fee guidelines."

Response Submitted by: Flahive, Ogden & Latson.

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 4, 2009	Pain Pump Refill - HCPCS Code J7799 KD	$1,500.00	$0.00
	CPT Code 95990	$77.04	$0.00
	CPT Code 77002	$96.89	$0.00
	CPT Code 62368	$72.47	$0.00
TOTAL		$1,746.40	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307, effective May 25, 2008, 33 *Texas Register* 3954, sets out the procedures for resolving a medical fee dispute.
2. 28 Texas Administrative Code §133.305 sets forth general provisions regarding dispute of medical bills.
3. 28 Texas Administrative Code §141.1 sets out the procedures for requesting and setting a Benefit Review Conference.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits
   - W11-Entitlement to benefits. Not finally adjudicated.
   - 851-Payment disallowed. Entitlement to benefits not finally adjudicated.

Issues

1. Does the documentation support that a compensability issue exists in this dispute?

Findings

1. The respondent denied reimbursement for the disputed services based upon reason code "W11 and 851."

   On May 29, 2003, the claimant sustained a compensable neck injury.

   A review of the submitted medical bills indicates that the disputed treatment was for the diagnosis: 722.81-Postlaminectomy Syndrome Cervical Region; 723.1-Cervicalgia; 723.4-Brachial Neuritis or Radiculitis NOS-Cervical Radiculitis; and 338.4-Chronic Pain Syndrome.

   The insurance carrier filed a PLN11 on March 8, 2005 disputing the extent of injury included the left shoulder.

   A review of the November 4, 2009 report indicates: "Pain Management: The patient is complaining of pain located in the neck and bil trapezius."

   28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "If a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   28 Texas Administrative Code §133.307(e)(3)(H) requires that if the carrier has raised a dispute pertaining to compensability, extent of injury, or liability for the claim, the Division shall notify the parties of the review requirements pursuant to §124.2 of this title, and will dismiss the request until those disputes have been resolved by a final decision, inclusive of all appeals. The appropriate dispute process for unresolved issues of compensability, extent and/or liability requires filing for a Benefit Review Conference pursuant to 28 Texas Administrative Code §141.1 prior to requesting medical fee dispute resolution.

   Review of the submitted documentation finds that there are unresolved issues of compensability, extent and/or liability for the same service(s) for which there is a medical fee dispute. No documentation was submitted to support that the issue(s) of compensability, extent and/or liability have been resolved prior to the filing of the request for medical fee dispute resolution.

   The requestor has failed to support that the disputed services are eligible for medical fee dispute resolution pursuant to 28 Texas Administrative Code §133.307.

Conclusion

For the reasons stated above, the requestor has failed to establish that the respondent's denial of payment reasons concerning liability for the injured employee's workers' compensation claim, compensability of that claim, and/or extent-of-injury issues with that claim have been resolved through the required dispute resolution process as set forth in Texas Labor Code Chapter 410 prior to the submission of a medical fee dispute request for the

same services. Therefore, medical fee dispute resolution staff has no authority to consider and/or order any payment in this medical fee dispute. As a result, no amount is ordered.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the services in dispute.

Authorized Signature

		2/14/2013
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.